

NOV 24 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

36164
Do not use this space.

1. PLACE OF DEATH

(a) County Iron Registration District No. 327
(b) Township Liberty Primary Registration District No. 5453
(c) City Liberty (d) Street No. _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

435 Samuel H Golden
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Maudie Golden</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Aug. 18 - 1873</u>		
7. AGE YEARS <u>66</u>	MONTHS <u>2</u>	DAYS <u>0</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>farmer</u>		
9. Industry or business in which work was done, as saw mill, bank, etc. _____		
10. Date deceased last worked at this occupation (month and year) _____		11. Total time (years) spent in this occupation _____
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>		
13. NAME <u>Chas. Golden</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>		
15. MAIDEN NAME <u>Mary Knolles</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>		
17. INFORMANT <u>Mrs. Urban Schick</u> (ADDRESS) <u>Kansas City Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Hony Creek Chapel</u> DATE <u>Oct 20</u> 19 <u>39</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>P. H. Raymondson</u> <u>Guth Mo</u>		
20. FILED <u>10-18-</u> 19 <u>39</u> <u>H. C. Weston</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 18 1939

22. I HEREBY CERTIFY, That I attended deceased from 9-30- 1939, to 10-18- 1939
I last saw him alive on 10-18- 1939. Death is said to have occurred on the date stated above, at 12:05 P. m.
The principal cause of death and related causes of importance were as follows:
Apoplexy
arteriosclerosis

Other contributory causes of importance: ?

Name of operation _____ Date of _____
What test confirmed diagnosis Clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) C. J. McClanahan M. D.
370 (Address) Spickard Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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RECEIVED

District Health Officer No. 11;
District No. 1139-1481
Date filed ---- NOV 8 1939

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

As Payne

Licensed Embalmer No. *2257*

P. O. Address..... *Galt Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.